OBSTETRICS.

UNDER THE CHARGE OF

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Prolapse of the Normally Situated Placenta.—STERN (*Monats. f. Geb. u. Gynäk.*, 1908, xxvii) reports the interesting case of a patient in her ninth pregnancy. Previous pregnancies had all been terminated by artificial help. There was no history as to the course of the third stage of labor in these cases. The present pregnancy had proceeded without disturbance. There was no sign of hemorrhage whatever. Stern was summoned to the patient by a midwife, because spontaneous labor had ceased. On examination the abdomen was greatly distended. The amniotic liquid was excessive in amount. The fœtus was small. The heart sounds were very faintly heard, and the fœtus occupied a transverse position. Uterine contractions were strong and there was no hemorrhage. On internal examination the cervix was completely dilated, the membranes unruptured and tense, and no evidence could be found of the placenta. An effort was made to turn the child internally, but this failed. The membranes were ruptured between the pains and the hand introduced to perform version. As soon as the membranes were ruptured a very strong pain developed, which closed the cervix so that but two fingers could be inserted. The amniotic liquid escaped freely, although the hand and arm were used as a plug to prevent its entire loss. As the last of the fluid escaped it was noticed that it was blood tinged. The uterus relaxed after the membranes were ruptured, and the finger on entering the cervix found the placenta. As the hand was introduced the entire placenta was found lying detached at the internal os. The child was immediately turned and extracted, and although it breathed a few times it did not survive. The placenta issued from the uterus without uterine contractions as soon as the head of the child escaped. The placenta was entire and there was no large retroplacental blood clot. The membranes had ruptured about 10 cm. from the border of the placenta, which was one of the points against placenta prævia. Examination of the body of the child showed death from asphyxia. These cases are to be distinguished from placenta prævia in its various forms, accidental separation of the normally implanted placenta accompanied by hemorrhage. In the present instance there was no hemorrhage either before, after, or during labor, and the placenta could not be found on internal examination until the cervix was completely dilated and the child was about to emerge. In the case cited the occurrence of polyhydramnios had undoubtedly something to do with the prolapse of the placenta. The sudden and great change in the intra-uterine tension following the escape of the amniotic liquid, may have been largely instrumental in the prolapse. As a predisposing cause of this accident one must recognize the abnormal conditions in the endometrium and the decidua, which are so frequently seen in placenta prævia.

Chorio-epithelioma, with Metastasis in the Vagina.—BRENNER (*Monats. f. Geburts. u. Gynäk.*, 1908, xxvii) concludes an interesting paper upon this subject. The case which he describes had never belonged in the category of cases of beginning typical malignant chorio-epithelioma, and arose from the proliferation of villi following the development of vesicular mole. The growth of the syncytium and its proliferated cells occurred in Langhans' layer; the wandering cells of the chorion arose from both Langhans' layer and the synctium. This could be demonstrated in the case reported. The development of the placenta seemed to be normal, but elements partly placental and partly foreign seemed to develop in the chorio-epithelioma. The character of the growth was essentially malignant, and its predominating feature was the rapid dissemination of syncytium. The degree of malignancy seems to depend upon the development of tissue in the tumor and tissue in the maternal organism as well. It is practically impossible to differentiate between the two. It is not yet clearly established that the syncytium arises from the chorion only; it may develop in part from the maternal tissue; in both epithelial and endothelial tissues are concerned. In the matter of diagnosis and prognosis the histological study of a given tumor is most important. When the tissues about the tumor are involved, operation should be preferably done by the vaginal route.

Extirpation of the Uterus for Difficult Labor following Vaginal Fixation.—ROSTHORN (*Monats. f. Geburts. u. Gynäk.*, 1908, xxvii) reports the case of a multipara who, two years previous to coming to the hospital, had vaginal fixation of the uterus done. During pregnancy there was great distention in the pelvic veins and those of the lower extremities. There was also disturbance in the function of the bladder. Labor developed very feebly and abnormally; the fœtus was in transverse position; the uterus enormously enlarged transversely, and there was no possibility for spontaneous labor. In endeavoring to introduce an elastic bag to dilate the cervix, the posterior vaginal wall, which was greatly stretched was ruptured; this was followed by very free hemorrhage which was controlled with difficulty by tampons. The abdomen was at once opened, the uterus opened, the child extracted, and the placenta removed. The posterior wall of the uterus was enormously distended and very thin; the anterior intra-uterine wall, over an area as large as the hand, was closely adherent to the vagina. A gauze tampon was used to shut off the abdominal cavity from the pelvis. The patient made a good recovery complicated by phlebitis in the lower extremity. On examining the uterus its contour had been completely altered and spontaneous labor, or even delivery by any method except section, would have been impossible.

The Supports in Chief of the Female Pelvic Viscera.—PARAMORE (*Jour. Obstet. and Gynec. Brit. Emp.*, June, 1908) reviews the literature of this subject and discusses the part played by intra-abdominal pressure and the levator ani muscle. He concludes that the pelvic viscera are maintained in their position by two sets of forces: The one acting from above pins the viscera in their position; this is the intra-abdominal pressure. The other from below supports the viscera and prevents them from being displaced by excessive force from above. These two forces vary with each other; the increase of the one produces the increase of the other. Both of these factors are under the control of the nervous system. The most essential element in maintaining the normal visceral position is supplied by the levator ani muscle. During defecation the visceral connective tissue is capable of supporting the viscera temporarily, but it is not capable of more than this. When this muscle becomes insufficient the viscera prolapse after a time.

In the same Journal, Fothergill discusses the pathology and operative treatment of displacement of the pelvic viscera. He concludes that in cases of classical prolapse anterior colporrhaphy, with union in the middle line of the parametric and paravaginal tissues, is indicated; with this should be performed posterior colporrhaphy and closure of the perineum. Ventrofixation in patients in whom conception cannot occur is indicated in addition, if necessary. When cystocele and vaginal prolapse are present, anterior colporrhaphy and closure of the perineum and pelvic floor are indicated. When the uterus is persistently retroverted and movable Alexander's operation is indicated, and when the uterus is fixed, abdominal section should be performed, adhesions separated, diseased appendages removed, and the uterus secured in anteversion.

The Excretion of Creatinin in Puerperal Patients and its Relation to Involution of the Uterus.—Longridge (*Jour. Obstet. and Gynec. Brit. Emp.*, June, 1908) made observations upon ten patients delivered in Queen Charlotte's Hospital, who had normal labors and recoveries. The patient's diet was regulated, consisting of milk, eggs, porridge, and bread and butter. The total nitrogen of the urine was estimated and the creatinin was determined by Folin's method. The percentage of nitrogen excreted as creatinin during the nine days following delivery varied from 4.2 on the first day to 3.2 on the ninth day. The average percentage for the whole puerperal period for creatinin is practically 3, which is the normal one for the excretion of endogenous creatinin. If creatinin is manufactured by muscular autolysis then its percentage should have been increased in these patients under the muscular exertion of labor. These results indicate that autolysis of the uterine muscle does not occur in normal cases. These results are in accord with those of Mellanby, who found in experiments in which bacteria were eliminated that creatin and creatinin are not produced by muscular contraction. The excretion of total nitrogen in these cases showed increase on the fifth and sixth days, and then decrease. During the first four days it varied but little. It seems rational to believe that this is the result of uterine involution. The uterus loses half its weight in normal involution during the first week, probably due to the comparative anemia of the uterus. This, however, is not entirely the result of anemia. Longridge believes that the development of sarcolactic acid in the uterine wall after delivery favors autolysis. After labor the uterus is left, if well contracted, in a comparatively anemic condition with diminished alkalinity. These two factors favor rapid autolysis. As the uterus becomes softer and the blood passes freely through it, it becomes alkaline, the products of autolysis are gradually removed, and its rate very much diminished. In rare cases, in which the patient loses blood greatly after labor, the uterus may undergo excessive involution and practically disappear.